

2018 Providence Medicare Advantage Plan Information

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

[Star Rating](#)

[Download Application](#)

Summary of Benefits: [Choice & Extra](#) / [Enrich](#) / [Prime](#) / [Compass & Latitude](#)

[Pharmacy & Provider Search](#)

[Formulary](#)

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: [Click here](#)
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: <https://medicare-oregon.com/>

Y0062_MULTIPLAN_CDA INSURANCE Oregon Accepted 2017

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):
Dann Loewenthal Date _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

PBP: _____

Tran. Code: _____

Plan #: _____

Premiums: _____

Group #: _____ Contract #: _____



A division of Providence Health Assurance

P.O. Box 5548
 Portland, OR 97228-5548

Providence Medicare Advantage Plans Enrollment Request Form

Please choose which plan you want to enroll in:

- Providence Medicare Prime + RX (HMO-POS) \$0
- Providence Medicare Choice (HMO-POS) \$45
- Providence Medicare Choice + RX (HMO-POS) \$88
- Providence Medicare Extra (HMO) \$109
- Providence Medicare Extra + RX (HMO) \$165
- Providence Medicare Compass + RX (HMO-POS) \$99
- Providence Medicare Latitude + RX (HMO-POS) \$169
- Providence Medicare Harbor + RX (HMO) \$0
- Providence Medicare Summit + RX (HMO-POS) \$59
- Providence Medicare Enrich + RX (HMO) \$146
- Providence Medicare Dual Plus (HMO SNP) \$0

Optional Supplemental Insurance

- OR Basic Dental \$33.70 premium will be added to your medical premium*
- OR Enhanced Dental \$46.50 premium will be added to your medical premium*
- WA Basic Dental \$35.50 (Summit and Harbor Plans) premium will be added to your medical premium*
- WA Enhanced Dental \$49.60 (Summit and Harbor Plans) premium will be added to your medical premium*

Please provide your information:			
<input type="checkbox"/> Mr.	LAST NAME	FIRST NAME	M.I.
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			
Date of Birth:	Sex:	Phone Number	
____/____/____ - - -	<input type="checkbox"/> Male	() -	
MM/DD/YYYY	<input type="checkbox"/> Female		
E-mail address:			
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code:
Mailing Address (ONLY if different from Permanent Residence Address):			
City:	County:	State:	ZIP Code:
Emergency Contact:			
Phone Number:		Relationship to you:	

Please Provide Your Medicare Insurance Information:	
<p>You must have Medicare Part A and Part B to join a Medicare Advantage Plan.</p> <ul style="list-style-type: none"> •Please fill out this information as it appears on your Medicare card. <p style="text-align: center;">-OR-</p> <ul style="list-style-type: none"> •Attach a copy of your Medicare Card or your letter from Social Security or Railroad Retirement Board 	<p>Name (as it appears on your Medicare card): _____</p> <p>Medicare Number: _____</p> <p>Is Entitled to: _____ Effective Date: _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p> <p>You must have Medicare Part A and B to join a Medicare Advantage Plan</p>

Attestation of eligibility for an enrollment period

Typically, you may enroll in a Medicare Advantage plan only during annual enrollment period from October 15th through December 7th of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Do any of the following statements apply to you? (Please check at least one)

- I am new to Medicare
- I am enrolling during the annual enrollment period or special enrollment period
- I am leaving employer or union coverage on (insert date):_____
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date):_____
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):_____
- I get extra help paying for my Medicare prescription drugs.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):_____
- I recently was released from incarceration. I was released on (insert date):_____
- I recently obtained lawful presence status in the United States. I got this status on (insert date):_____
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving help on (insert date):_____
- I am moving into, live in, or recently moved out of a Long-Term Care Facility.
I moved/will move into the facility on (insert date):_____
- I moved/will move out of the facility on (insert date):_____
- I recently left a PACE program on (insert date):_____
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date):_____
- I was impacted by a significant network change with my current plan and was notified on (insert date):_____
- Other qualifying event(s) (please list):_____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY: 711) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

Important Questions	
<p>1. Do you have End-Stage Renal Disease (ESRD)?</p> <p>If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If we don't receive a note or records from your doctor we may need to contact you to obtain additional information.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Do you or your spouse work?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Will you have other coverage in addition to Providence Medicare Advantage Plans?</p> <p>Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.</p> <p>Please list your other coverage and your identification (ID) number for this coverage:</p> <p>Name of other coverage: _____</p> <p>ID # for this coverage: _____</p> <p>Group # For this Coverage: _____</p> <p>Check all that apply: <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Are you a resident in a long-term care facility, such as a nursing home?</p> <p>If yes, please provide the following information:</p> <p>Name of Institution: _____</p> <p>Address of Institution: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone Number of Institution: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Are you enrolled in a State Medicaid program?</p> <p>If "yes", please provide your Medicaid number: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Please choose the name of a Primary Care Provider (PCP): _____</p> <p>Clinic name/PCP location: _____</p>	
<input type="checkbox"/> Please send me my Evidence of Coverage as an audio CD	

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY: 711) if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

Paying your plan premium

You can pay your monthly premium, including any late enrollment penalty that you may currently have or may owe by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option

Receive a monthly bill

Electronic Funds Transfer (EFT) from your bank. This will occur between the 15th and the 20th of each month and is the same date for all members. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank Routing Number: _ _ _ _ _

Bank Account Number: _ _ _ _ _

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: Social Security RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security/RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bills for your monthly premiums.)

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Providence Medicare Advantage Plans the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance.

Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Providence Advantage Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Providence Advantage Plans.

Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefit administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Providence Medicare Advantage Plans is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or maybe get in the future. I understand that if I don't have Medicare prescription drug coverage, or a creditable prescription drug coverage plan (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year, when an enrollment period is available (Example: October 15th –December 7th of every year), or under certain special circumstances.

Providence Medicare Advantage Plans serves a specific service area. If I move out of the area that Providence Medicare Advantage Plans serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Providence Medicare Advantage Plans, I have the right to appeal plan decisions about payment or service if I disagree.

I will read the Evidence of Coverage from Providence Medicare Advantage Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country expect for limited coverage near the U.S. boarder.

I understand that selecting a Providence Medicare (HMO) plan means that on the date coverage begins; I must get all of my health care from Providence Medicare Advantage Network Providers, except for emergency or urgently needed services or out-of-area dialysis services. I understand that selecting a Providence Medicare HMO-POS plan means that with some exceptions, I may get non-urgent or non-emergent health care from providers outside the Providence Medicare Advantage Network at a higher cost-sharing should I choose.

Services authorized by Providence Medicare Advantage Plans and other services contained in my Providence Medicare Advantage Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered provided plan rules are followed. If plan rules are not followed, **NEITHER MEDICARE NOR PROVIDENCE MEDICARE ADVANTAGE PLANS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Providence Medicare Advantage Plans, he/she may be paid based on my enrollment in Providence Medicare Advantage Plans.

Authorization and Declaration

Release of information: By joining this Medicare health plan, I acknowledge that Providence Medicare Advantage Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Providence Medicare Advantage Plans will release my information including my prescription drug event data if I am on a prescription drug plan to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by and authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare. **Applicant sign below:**

Signature: _____

If the applicant is unable to sign the application and you are the authorized representative, please sign above and provide the requested information below:

Name: _____

Address: _____

Relationship to enrollee: _____ Phone Number (____) _____ - _____

Agent Name: _____ Date: _____

ID #: _____

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-603-2340 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-603-2340 (TTY: 711) ។

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-603-2340 (TTY: 711) まで、お電話にてご連絡ください。

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711)።

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni agama. Bilbilaa 1-800-603-2340 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم 711 TTY).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-603-2340 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

Thai: หมายเหตุ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-603-2340 (TTY: 711) تماس بگیرید.

Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with a Medicare and Oregon Health Plan contract. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

H9047_2017PHP24 ACCEPTED

MDP-023E